the nature of the arrangements is most like an under ''arrangement'' situation, although technically the provider may treat the therapists as employees. The intent of this section is to prevent an employment relationship from being used to circumvent the guidelines.

(6) These provisions are applicable to individual therapy services or disciplines by means of separate guidelines by geographical area and apply to costs incurred after issuance of the guidelines but no earlier than the beginning of the provider's cost reporting period described in paragraph (a) of this section. Until a guideline is issued for a specific therapy or discipline, costs are evaluated so that such costs do not exceed what a prudent and cost-conscious buyer would pay for the given service.

(d) *Notice of guidelines to be imposed.* Prior to the beginning of a period to which a guideline will be applied, a notice will be published in the FEDERAL REGISTER establishing the guideline amounts to be applied to each geographical area by type of therapy.

(e) *Additional allowances.* (1) If a therapist supervises other therapists or has administrative responsibility for operating a provider's therapy department, a reasonable allowance may be added to the adjusted hourly salary equivalency amount by the intermediary based on its knowledge of the differential between therapy supervisors' and therapists' salaries in similar provider settings in the area.

(2) If a therapist performing services under arrangements furnishes equipment and supplies used in furnishing therapy services, the guideline amount may be supplemented by the cost of the equipment and supplies, provided the cost does not exceed the amount the provider, as a prudent and cost-conscious buyer, would have been able to include as allowable cost.

(f) *Exceptions.* The following exceptions may be granted but only upon the provider's demonstration that the conditions indicated are present:

(1) *Exception because of unique circumstances or special labor market conditions.* An exception may be granted under this section by the intermediary if a provider demonstrates that the costs for therapy services established by the guideline amounts are inappropriate to a particular provider because of some unique circumstances or special labor market conditions in the area.

(2) *Exception for services furnished by risk-basis HMO providers.* For special rules concerning services furnished to an HMO's enrollees who are Medicare beneficiaries by a provider owned or operated by a risk-basis HMO (see § 417.201(b) of this chapter) or related to a risk-basis HMO by common ownership or control (see § 417.250(c) of this chapter).

(3) *Exception for inpatient hospital services.* Effective with cost reporting periods beginning on or after October 1, 1983, the costs of therapy services furnished under arrangements to a hospital inpatient are excepted from the guidelines issued under this section if such costs are subject to the provisions of § 413.40 or part 412 of this chapter. The intermediary will grant the exception without request from the provider.

(g) *Appeals.* A request by a provider for a hearing on the determination of an intermediary concerning the therapy costs determined to be allowable based on the provisions of this section, including a determination with respect to an exception under paragraph (f) of this section, is made to the intermediary only after submission of its cost report and receipt of the notice of amount of program reimbursement reflecting such determination, in accordance with the provisions of subpart R of part 405 of this chapter.

[51 FR 34793, Sept. 30, 1986, as amended at 63 FR 5139, Jan. 30, 1998]

§ 413.114 Payment for posthospital SNF care furnished by a swing-bed hospital.

(a) *Purpose and basis.* This section implements section 1883 of the Act, which provides for payment for posthospital SNF care furnished by rural hospitals and CAHs having a swing-bed approval.

(1) *Services furnished in cost reporting periods beginning prior to July 1, 2002.* Posthospital SNF care furnished in general routine inpatient beds in rural

hospitals and CAHs is paid in accordance with the special rules in paragraph (c) of this section for determining the reasonable cost of this care. When furnished by rural and CAH swing-bed hospitals approved after March 31, 1988 with more than 49 beds (but fewer than 100), these services must also meet the additional payment requirements set forth in paragraph (d) of this section.

(2) *Services furnished in cost reporting periods beginning on and after July 1, 2002.* Posthospital SNF care furnished in general routine inpatient beds in rural hospitals (other than CAHs) is paid in accordance with the provisions of the prospective payment system for SNFs described in subpart J of this part, except that for purposes of this paragraph, the requirements of §413.343(a) must be met using the specific assessment instrument and data designated by CMS for this purpose. Posthospital SNF care furnished in general routine inpatient beds in CAHs is paid based on reasonable cost for cost reporting periods beginning on and after July 1, 2002 and before January 1, 2004, and is paid based on 101 percent of reasonable cost for cost reporting periods beginning on and after January 1, 2004, in accordance with the provisions of subparts A through G of this part (other than paragraphs (c) and (d) of this section).

(b) *Definitions.* For purposes of this section—

Availability date means with respect to a posthospital SNF care patient in a swing-bed hospital, the later of—

(i) Any date on which a bed is available for the patient in a Medicare-participating SNF located within the hospital's geographic region;

(ii) The date that a hospital learns that a bed is available in a Medicare-participating SNF; or

(iii) If the notice is prospective, the date that a bed will become available in a Medicare-participating SNF.

Geographic region means an area that includes the SNFs with which a hospital has traditionally arranged transfers and all other SNFs within the same proximity to the hospital. In the case of a hospital without existing transfer practices upon which to base a determination, the geographic region is an area that includes all the SNFs within 50 miles (as defined in §412.92(c)(1) of this chapter) of the hospital unless the hospital can demonstrate that the SNFs are inaccessible to its patients. In the event of a dispute as to whether an SNF is within a hospital's geographic region or the SNF is inaccessible to hospital patients, the CMS Regional Office makes a determination.

Swing-bed hospital means a hospital or CAH participating in Medicare that has an approval from CMS to provide posthospital SNF care as defined in §409.20 of this chapter, and meets the requirements specified in §482.66 or §485.645 of this chapter, respectively.

(c) *Special rules for determining the reasonable cost of posthospital SNF care furnished in cost reporting periods beginning prior to July 1, 2002.* The reasonable cost of posthospital SNF care furnished by a swing-bed hospital is determined as follows:

(1) The reasonable cost of routine SNF services is based on the average Medicare rate per patient day for routine services provided in freestanding SNFs in the region where the swing-bed hospital is located. The rates are calculated using the regions as defined in section 1886(d)(2)(D) of the Social Security Act. The rates are based on the most recent year for which settled cost reporting period data are available, increased in a compounded manner, using the increase applicable to the SNF routine cost limits, up to and including the calendar year for which the rates are in effect. If the current Medicare swing-bed rate for routine extended care services furnished by a swing-bed hospital during a calendar year is less than the rate for the prior calendar year, payment is made based on the prior calendar year's rate.

(2) The reasonable cost of ancillary services furnished as posthospital SNF care is determined in the same manner as the reasonable cost of other ancillary services furnished by the hospital in accordance with §413.55(a)(1).

(d) *Additional requirements*—(1) *General rule.* For services furnished in cost reporting periods beginning prior to July 1, 2002, in order for Medicare payment to be made to a swing-bed hospital with more than 49 beds (but fewer

than 100), the following payment requirements must be met:

(i) If there is an available SNF bed in the geographic region, a posthospital SNF care patient must be transferred within 5 days (excluding weekends and holidays) of the availability date, unless the patient's physician certifies within the 5-day period that transfer is not medically appropriate.

(ii) The number of patient days for posthospital SNF care in a cost reporting period does not exceed 15 percent of the product of the number of days in the period and the average number of licensed beds in the hospital in the period. In those States that do not license their hospital beds, the hospitals must use the total number of hospital beds reported on their most recent Certificate of Need (CON), excluding bassinets. If during the cost reporting period, there is an increase or decrease in the number of ''licensed'' beds, the number of ''licensed'' beds for each part of the period is to be multiplied by the number of days for which that number of ''licensed'' beds was available. After totalling the results, compute 15 percent of the total available ''licensed'' bed days to determine the payment limitation.

(2) *Payment restrictions.* (i) The hospital must not seek payment for posthospital SNF care after the end of the 5 day period (excluding weekends and holidays) beginning on the availability date of a SNF bed unless the patient's physician has certified, within that 5 day period, that the transfer of the patient to the SNF was not medically appropriate.

(ii) The hospital must not seek payment for posthospital SNF care in a cost reporting period to the extent that they exceed 15 percent of the product of the number of days in the period and the average number of licensed beds in the period. In those States that do not license hospital beds, the hospital must use the average number of hospital beds reported on its most recent CON, excluding bassinets.

(3) *Payment exception.* Payment will continue to be made during the cost reporting period in which the 15 percent limit specified in paragraph (d)(1)(ii) of this section is reached for those patients who are receiving posthospital SNF care at the time the hospital reaches the limit.

[51 FR 34793, Sept. 30, 1986, as amended at 54 FR 37274, Sept. 7, 1989; 56 FR 54545, Oct. 22, 1991; 58 FR 30671, May 26, 1993; 61 FR 51616, Oct. 3, 1996; 62 FR 46037, Aug. 29, 1997; 66 FR 39600, July 31, 2001; 69 FR 49265, Aug. 11, 2004]

§ 413.118 Payment for facility services related to covered ASC surgical procedures performed in hospitals on an outpatient basis.

(a) *Basis and scope.* This section implements section 1833(a)(4) and (i)(3) of the Act and establishes the method for determining Medicare payments for services related to covered ambulatory surgical center (ASC) procedures performed in a hospital on an outpatient basis. It does not apply to services furnished by an ASC operated by a hospital that has an agreement with CMS to be paid in accordance with § 416.30 of this chapter. (For regulations governing ASCs see part 416 of this chapter.)

(b) *Definitions.* For purposes of this section—

Facility services are those items and services, as specified in § 416.61 of this chapter, that are furnished by a hospital on an outpatient basis in connection with covered ASC surgical procedures, as described in § 416.65 of this chapter.

Standard overhead amount means an amount equal to the prospectively determined payment rate that would be paid for the procedure if it had been furnished by an ASC in the same geographic area.

(c) *Payment principle.* The aggregate amount of payments for facility services, furnished in a hospital on an outpatient basis, that are related to covered ASC surgical procedures (covered under § 416.65 of this chapter) is equal to the lesser of—

(1) The hospital's reasonable cost or customary charges, as determined in accordance with § 413.13, reduced by deductibles and coinsurance; or

(2) The blended payment amount as described in paragraph (d) of this section, which is based on hospital-specific cost and charge data and rates paid to free-standing ASCs.

(d) *Blended payment amount.* (1) For cost reporting periods beginning on or